Dynamic Chiropractic

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Should I Reduce My Bill?

Kenneth Satin, JD

It is a common practice for attorneys handling personal injury cases to request the doctor of chiropractic to reduce his outstanding balance at the time of the settlement of the claim.

An often posed question is whether or not it is advisable for the DC to honor that request.

The typical scenario is one in which the DC has been treating the accident-injured patient for three to nine months. Let us presuppose that the outstanding balance is in the amount of $4,000.

For purposes of our hypothetical case, we will assume there is no billable insurance, i.e., no health insurance or "med-pay" coverage in sight and that the doctor has been treating the patient "on lien."

Ultimately the patient is declared "permanent and stationary" with the doctor's report indicating that the injuries are soft-tissue in nature with a guarded prognosis and that future care is likely.

Let us further presuppose that the doctor-patient relationship is a positive one and that the doctor has done an excellent job in relieving the patient's symptomatology and providing significant pain relief.

Ultimately, the final narrative report was timely transmitted to the attorney who submitted that report as a part of his settlement package to the insurance carrier for the responsible party. That carrier has settled the claim with the attorney or is now prepared to do so.

Unexpectedly, the doctor of chiropractic receives a call from the attorney representing the patient who firmly insists that the doctor reduce his bill on the basis that the attorney will not be able to net his client enough money (so as to obtain the client's permission to settle) unless the bill is lowered. In determining whether or not the request for a reduction should be granted there are several considerations as follows:

1. Is the statement in keeping with customary per visit charges? If the DC has charged his patient the "going rate" for his particular area and if his charges are not beyond what other doctors of chiropractic would charge per visit in the area, this should weigh heavily as to whether or not the DC should grant the reduction. If the charges are in keeping as to per visit charges, this would be one factor against granting the request for a reduction.

2. Does the statement contain an unreasonable amount of "diagnostic" vs. "treatment" charges? Insurance companies will penalize the patient and his attorney in negotiating the claim if a substantial percentage of the statement relates to diagnostic charges such as x-rays, thermograms, MRI studies, etc. (as opposed to treatment). As a general "rule of thumb," the higher the percentage of diagnostic charges, the more the DC should be inclined to grant the request for reduction.

3. Has the DC treated the patient for an extended period of time? Insurance adjusters routinely believe that everyone should be free of soft-tissue injuries in a maximum of 90 days. While this is not medically established, this is, nevertheless, the perception of the insurance adjuster. In this attorney's viewpoint, if the treatment has extended beyond six months, this would be a factor the doctor of chiropractic should consider in favor of granting the request for reduction.

4. Did the DC have an orthopedic consultation take place? One of the routinely raised defenses of insurance adjusters is that after the 90 day period of treatment, the doctor of chiropractic should have had the patient seen by an orthopedist who, if necessary, would have recommended additional chiropractic treatment. If this did not take place, this would be a factor leaning toward granting the reduction.

5. Does this attorney always ask for a reduction or is this requested only selectively? If the attorney asks for a reduction in every single instance, this would be a factor leaning away from granting the reduction. If, on the other hand, this happens rarely and only when necessary, the DC should consider the request.

6. Does the amount of charges exceed insurance carrier thresholds? This author's experience is limited primarily to California. The DC should consult the attorney as to what the threshold (maximum) charges are that the insurance company believes reasonable.

   In Southern California, for example, $3,500 to $4,000 appears to be the maximum insurance companies consider appropriate for all treatment (including emergency room care) for soft tissue injuries. Beyond that, the insurance companies often do not consider any billing over that amount in evaluating the claim and suggest to the attorney that reductions from the medical care providers are in order.

7. What if the attorney indicates that the bills have been evaluated by "peer review?" An often-used ploy of insurance companies is to send the doctor's charges and records to an independent company for purposes of determining whether they are reasonable or appropriate.

   Invariably that company provides the insurance company with a report indicating that the charges are at least 30 to 50 percent too high.

   The insurance company then uses the charges (as that organization recommends they should be) as the basis to evaluate the claim rather than the charges which actually exist.

   The insurance company then routinely indicates that the attorney should talk to the chiropractor about having the bills reduced to what the peer review suggests. If the charges are substantially over what peer review indicates they should be, this should be a factor toward granting the request for reduction.

8. If the doctor of chiropractic is inclined towards granting a reduction, how much of a reduction should be granted? This is an issue which needs to be handled on a case-by-case basis, but the typical reduction request is 20 to 30 percent of the outstanding balance.

9. Why should the doctor of chiropractic consider the grant of a reduction if the attorney isn't reducing his bill? As the doctor of chiropractic hates to reduce his bill, the attorney hates to reduce his fee. The reason typically raised by attorneys, however, as to why the doctor should reduce his bill and the attorney should not is because 25 to 33.3 percent is routinely charged by most attorneys throughout the United States as the contingent fee in personal injury cases. That is a widely known fact. If peer review indicates that the chiropractic bill (either as to its amount of diagnostic, length of treatment, per visit charges, etc.) is beyond what is standard and customary, the attorney will probably indicate that his bill is standard and customary while the doctor's is not (and that is why the doctor should reduce his bill).

10. Should the doctor consider whether or not he has a pre-existing relationship with this attorney? The answer is obviously in the affirmative. If the attorney and the doctor have a mutual referral relationship and have worked together and continue to work together in the future, this would be factor leaning toward granting the reduction.

11. Should the doctor of chiropractic concern himself with the extent of impact? Typically the first question asked by the insurance adjuster is the extent of property damage to the subject vehicle. A $500 impact will raise suspicion in the mind of the adjuster if there is $3,000 worth of treatment. On the other hand, a $7,000 impact may justify (in the insurance adjuster's mind) $6,000 worth of treatment. While it is common knowledge among attorneys and doctors that a light impact may produce a serious injury and that it is possible for a serious impact to produce virtually no injury at all, that is not the perspective of the insurance carrier. For purposes of determining whether or not there will be ease in negotiation and whether or not the chiropractor will be asked to reduce his bill, the DC should find out from the law firm involved how much impact occurred. It may have a bearing (from the insurance carrier's point of view) on how much treatment is justifiable.

12. Does the length of time processing a case have any bearing? In most jurisdictions it takes several years to process a case to trial. Even if arbitration (alternative dispute resolution) approach is used, this process can still take one year or longer.

If the doctor is on lien, he is typically not receiving interest on his outstanding balance and must wait to be paid until the case is over. The cost of money is a consideration. If the DC's cash flow requirements are considered, this may be a factor leaning in favor of granting a reduction.

When attempting to negotiate a personal injury case, the attorney is faced with a dilemma. No longer does the insurance typically play "three times specials." If such a formula were to be used (although it has been generally discarded), the amount being paid for soft tissue injuries in these times is closer to twice specials.

Of course, any such formula is ridiculous. Different doctors charge different amounts for the same services. Evaluation of a claim must be on an individualized basis. In this author's experience, however, whether the chiropractic charges are $3,500, $4,500, $5,500 or even $6,500, the offers are typically the same. In other words, if the charges are over $3,500, a point of diminishing returns has been reached.

Needless to say, the attorney and doctor of chiropractic must work closely together in order to discuss the foregoing and arrive at a mutual understanding in advance as to the appropriate

manner in which a case should be handled through the course of treatment.

Kenneth A. Satin, J.D.
Newport Beach, California

Editor's Note:

Mr. Kenneth A. Satin's law firm is located at 4000 McArthur Street, Suite #950, Newport Beach, California 92660 (714) 851-1163. We thank Mr. Satin for providing this series of articles for our readers.

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